Statement to the Senate Special Committee on Aging

A Time for Solutions: Finding Consensus in the Medicare Reform Debate

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Thank you, Chairman Kohl, Ranking Member Corker, and members of the Committee for the opportunity to discuss Medicare reforms that can responsibly slow the growth of program spending and help set this country on a sustainable fiscal path.

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Numerous experts, commissions, and other organizations have advanced a variety of proposals intended to strengthen the economy and bolster the nation's fiscal health. There is a broad consensus that slowing the growth of federal health spending is essential if we are to achieve these goals. Federal health spending has grown faster than the economy since the creation of Medicare and Medicaid in 1965. Unless strong action is taken, federal health spending will continue to outpace the economy for the indefinite future.

Medicare reform is essential if we expect to avert this crisis. Medicare spending will double over the next decade, increasing from $555 billion in 2011 to more than $1 trillion annually in the early 2020s.[1] The first of the baby boom generation turned 65 this year and enrolled in Medicare. Over the next two decades, some 70 million people will move out of the work force, into retirement and into Medicare. That will place an increasing burden on the budget and on younger generations whose taxes support the program.

The Budget Control Act creates an opportunity for Congress to address these serious issues. The Joint Select Committee on Deficit Reduction is charged with developing a plan that would reduce the federal deficit by at least $1.2 to $1.5 trillion, and the Act provided expedited procedures to permit enactment of the plan by December 23. There is a growing consensus among policymakers and the public that Congress should adopt prudent policies to avert fiscal calamity.

Although Medicare reform remains controversial, there are also important areas of agreement, at least among policy experts. Immediate action can be taken on those areas of agreement, which would allow policymakers more time to focus on more fundamental disagreements. However, the adoption of less complex and less controversial deficit-reduction options does not absolve Congress from grappling with structural reforms necessary to ensure that Medicare will continue to provide essential health benefits for future generations.

A Basis for Agreement

The ongoing arguments about Medicare reform reflect fundamentally different philosophies about the role of government. Should reform rely more on the government to hold down the prices of health services, maintain quality standards, and protect consumers? Or

[1] Congressional Budget Office (CBO), *The Budget and Economic Outlook: An Update*, August 2011.

should reform give consumers a stronger voice in their own health care by allowing them to choose the coverage they want at a subsidized price they are willing to pay? Do we rely on government regulation or market incentives in Medicare and the health system?

As stark as those discussions often are, there are common elements that run through the arguments on both sides. The basic question is not all or nothing. The argument is over where we draw the line between government control and market incentives. There will be regulation, whether it is a government-issued rule or one established by a private insurer. There will be unpredictable changes in the health system as consumers, providers, insurers, and employers respond to those rules, no matter how tightly written they may seem. Consensus will develop around a Medicare reform that sets a reasonable balance between regulation and incentives.

Conceptual agreement is possible on other pressing issues. I offer three examples.

First, redistribution. Washington Post columnist Robert Samuelson calls Medicare "middle class welfare" because of the generous benefits provided to people who are economically secure and relatively healthy.[2] Medicare's premiums for Part B and Part D are income-related, but higher-income beneficiaries still receive substantial benefits. Eugene Steuerle and Stephanie Rennane estimate that a single-earner couple turning 65 in 2010 will receive $351,000 in Medicare benefits (measured in present value terms) over their lifetimes, but they paid only $58,000 in payroll taxes and Medicare premiums.[3] According to those calculations, higher income individuals pay more into the system but those payments do not approach the expected benefits paid by Medicare.

Many argue that the program should be made more progressive. The Heritage Foundation, for example, proposes to phase out the subsidy for Medicare benefits to beneficiaries with comes over $55,000 (for individuals) or $110,000 (for couples).[4] The subsidy is eliminated for individuals with incomes over $110,000 or couples with incomes over $165,000. They could enroll in Medicare but would receive no government contribution and pay full, unsubsidized premiums—not only for Part B and Part D, but for all the benefits covered by Medicare.

Other expert groups have proposed to increase the progressivity of Medicare, including the American Enterprise Institute, William Galston and Maya MacGuineas, Senators Lieberman and Coburn, and Alice Rivlin and Paul Ryan.[5] Medicare already requires higher income beneficiaries to pay more, so that political barrier has been broken without undermining support

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[2] Robert J. Samuelson, "Who rules America? AARP." *Washington Post*, February 21, 2011, available at http://www.washingtonpost.com/wp-dyn/content/article/2011/02/20/AR2011022002482.html.

[3] C. Eugene Steuerle and Stephanie Rennane, "Social Security and Medicare Taxes and Benefits Over a Lifetime," Urban Institute, June 2011, http://www.urban.org/UploadedPDF/social-security-medicare-benefits-over-lifetime.pdf.

[4] Stuart Butler, Alison Acosta Fraser, and William Beach, *Saving the American Dream: The Heritage Plan to Fix the Debt, Cut Spending, and Restore Prosperity*, Heritage Foundation, Special Report #91, May 10, 2011, http://www.heritage.org/research/reports/2011/05/saving-the-american-dream-the-heritage-plan-to-fix-the-debt-cut-spending-and-restore-prosperity.

[5] A summary of Medicare reform proposals is available from the Kaiser Family Foundation, "Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals," September 23, 2011, http://www.kff.org/medicare/upload/8124.pdf.

for the program. In the face of rising fiscal pressure, there is no reason why Medicare's subsidy cannot be targeted on those who need help the most.

Second, honest Medicare budgeting. Public confidence in government depends greatly on whether policies are stable and predictable. Frequent changes in the way government is administered breeds cynicism and distrust. They cause individuals and businesses to take actions that are inefficient and wasteful to protect themselves against the uncertainty of the political process.

Medicare's sustainable growth rate (SGR) policy is a case in point. The SGR was established to limit the growth of Medicare physician spending. Beginning in 2003, Congress has overridden the reductions in payment rates determined by the SGR.[6] Since the SGR formula is cumulative, the size of the required fee reduction has increased. As a result, physician payment rates will be reduced by 29.4 percent beginning January 1, 2012, unless Congress takes action.

There is widespread agreement that a nearly 30 percent cut in physician fees is unreasonable and universal expectation that Congress will do something about it, as it has for the past eight years. That expectation does nothing to reduce the anxiety or the intensive lobbying that accompanies this annual charade.

Previous legislation to defer the SGR reduction has granted relief for one year or less to minimize the amount of the budget offset needed to keep the policy budget neutral. According to CBO, a one-year "fix" setting the physician payment update to 0 for 2012 would cost $22 billion through 2021.[7] But enacting a fix one year at a time only appears to limit the budget impact.

The total additional spending over a decade will be the same whether the rate increases are made a year at a time or all at once. A permanent fix that builds no inflation into physician payments would cost $298 billion through 2021, and one that allows payment rates to grow with the Medicare Economic Index would cost $358 billion.

The Joint Select Committee has an opportunity to resolve this problem and place Medicare physician payment policy on a politically realistic path that future Congresses will be willing to accept. Another short-term fix makes the budget problem worse and further degrades public confidence in the legislative process.

Third, shared sacrifice. If a rising tide lifts all boats, a falling tide lowers them. CBO estimates that the debt to GDP ratio will reach 67 percent this year.[8] The Committee for a Responsible Federal Budget estimates that the debt could reach 90 percent of GDP by 2021

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[6] Jim Hahn, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, Congressional Research Service, Report R40907, August 6, 2010, http://aging.senate.gov/crs/medicare15.pdf.
[7] CBO, "Medicare's Payments to Physicians: The Budgetary Impact of Alternative Policies," June 16, 2011, http://www.cbo.gov/ftpdocs/122xx/doc12240/SGR_Menu_2011.pdf.
[8] CBO, *The Budget and Economic Outlook: An Update*, August 2011.

under current policies.[9] Medicare will have to do its part to help put the country on a sustainable course. That means cutting overall program costs even when there are circumstances, such as the physician payment problem, which call for increasing costs in a specific area. That will not be easy in the politically-charged context of health care.

On October 6, 2011, the Medicare Payment Advisory Committee (MedPAC) approved a set of recommendations to offset the cost of repealing the SGR.[10] Those costs would be shared by physicians, other health professionals, providers in other sectors, and beneficiaries. Under the proposal, primary care physicians would be subject to a ten year payment freeze and payments to specialists would be cut 5.9 percent each year for three years followed by a seven-year payment freeze. Some of the other offsets come from durable medical equipment, hospitals and Medicare benefits to seniors.[11]

This recommendation for shared sacrifice was not welcomed by those asked to sacrifice.[12] The American Medical Association and 42 other medical organizations argued that the SGR repeal should not be funded by instituting other kinds of cuts in Medicare physician payment.[13] Richard Umbdenstock, president and CEO of the American Hospital Association, wrote that offsetting the cost of the SGR repeal with Medicare cuts to hospitals and other providers is an approach equivalent to "robbing Peter to pay Paul."[14]

That comment characterizes one of the problems with regulatory price-setting schemes that are typical in Medicare: organizations attempt to gain financial advantage at the expense of others ("rob Peter to pay Paul") through the political process. This "rent-seeking" behavior diverts resources from productive activities that could provide greater value to patients.

Near-Term Options

A realistic Medicare reform package that could be considered by the Joint Select Committee must satisfy several requirements. The provisions must yield substantial program savings within the ten-year budget window, which means that they can be implemented fairly rapidly and their capacity to reduce program spending is reasonably clear-cut. At the same time, however, at least some provisions must be forward-looking and, ultimately, risky. Business as usual with a few tweaks will not be effective in preserving Medicare for the long term.

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[9] Committee for a Responsible Federal Budget, "What Needs to Come Out of the Debt Ceiling Negotiations," June 21, 2011, http://crfb.org/sites/default/files/What_Needs_to_Come_Out_of_Debt_Ceiling_Negotiations.pdf.
[10] Stephanie Bouchard, "MedPAC approves SGR repeal proposal," Healthcare Finance News, October 7, 2011, http://www.healthcarefinancenews.com/news/medpac-approves-sgr-repeal-proposal.
[11] Rich Daly, "MedPAC offers path to SGR repeal," Modern Healthcare, October 6, 2011, http://www.modernhealthcare.com/article/20111006/NEWS/310069989/medpac-offers-path-to-sgr-repeal#.
[12] Bob Herman, "AHA, AMA Urge MedPAC to Consider Other Issues With SGR," Becker's Hospital Review, October 5, 2011, http://www.beckershospitalreview.com/racs-/-icd-9-/-icd-10/aha-ama-urge-medpac-to-consider-other-issues-with-sgr.html.
[13] American Medical Association, Letter to Glenn M. Hackbarth, October 3, 2011, http://www.ama-assn.org/resources/doc/washington/sgr-repeal-specialty-sign-on-letter.pdf.
[14] Richard J. Umbdenstock, Letter to Glenn M. Hackbarth, October 3, 2011, http://www.aha.org/advocacy-issues/letter/2011/111004-let-umbdenstock-hackbarth.pdf.

Near-term provider cuts. Because Medicare is a complex program with many moving parts, the list of budget options to reduce program spending that could be implemented quickly is lengthy and highly technical. Refinements in payment systems, adjustments in coding medical services, modifications in conditions under which Medicare will pay for a service, and changes in administrative oversight could produce scoreable savings that can help the Joint Select Committee's bottom line.

The Medicare Payment Advisory Commission's initial list of proposals to offset the cost of abolishing the SGR is illustrative.[15] MedPAC combed through their own previous reports as well as budget options proposed by the Congressional Budget Office, the Department of Health and Human Services, and the President's budget to identify 29 specific provisions offering a combined ten-year savings of $233 billion.

Nearly all of MedPAC's offsets are aimed at health care providers and suppliers. Fee-for-service payments hospitals, home health agencies, and post-acute care facilities would be trimmed. Payments would be cut for inappropriate readmissions. Prior authorization would be required for medical imaging performed by physicians identified as high utilizers. Payment reductions would be taken for durable medical equipment. Pharmaceutical manufacturers would be required to pay a rebate to the federal government (in effect, a tax) for sales of prescription drugs to low-income beneficiaries under Medicare Part D.

None of those provisions change the underlying economic incentives associated with fee-for-service medicine. Most tighten payment rates without attempting to promote greater efficiency or better value for patients. Prior authorization attempts to directly curb unnecessary use of services, but this approach only backfills against flawed payment incentives that are the root cause of the problem.

Simple price cuts do not address the problems inherent in Medicare's fee-for-service payment system. Since traditional Medicare sets thousands of prices, it is impossible for the program to set relative prices of specific services to accurately reflect their value to the patient. As a result, relatively overpriced services will be in greater use when there is a choice, and that makes the care delivered less efficient.

The political virtues of provider cuts cannot be denied. By focusing budget pressure on providers and suppliers, policymakers can assert that benefits would not be reduced and patients would not be harmed. That claim may appear to be true, at least when such cuts are modest and of short duration. Providers and medical suppliers will see their incomes and profit margins decline, and may not immediately respond to lower Medicare payments by changing the way they function.

Just as there is no free lunch, there are no painless Medicare cuts. One of the main goals of Medicare reform is to free up resources for other uses, but that comes with consequences. Lower payments eventually result in reduced access to services and slower introduction of new

[15] Medicare Payment Advisory Commission (MedPAC), "Draft Offset List," September 15, 2011, http://www.medpac.gov/transcripts/Draft%20Offset%20List%20for%20Public.pdf. At the time this statement was written, the final list of recommendations approved by MedPAC was unavailable.

technology and innovative treatments. Some short-term options have greater long-term impact on access and medical progress than others. That should be weighed carefully by the Joint Select Committee as they develop their final deficit reduction package.

Near-term program restructuring. Other deficit reduction options that could produce scoreable savings in the near term would directly affect some aspects of Medicare's interaction with beneficiaries. Such changes would be relatively modest and would not fundamentally change the way traditional Medicare operates. They include increasing cost-sharing requirements, instituting targeted care management programs for high-cost patients, and raising Medicare premiums. A politically more ambitious option is to raise Medicare's eligibility age.

Cost-sharing requirements—deductibles, copayments, and coinsurance—are included in the design of Medicare and other health insurance to promote more prudent use of services. Requiring some out-of-pocket payment increases the patient's cost awareness, which reduces utilization. Private plans typically have a single deductible that applies to all covered services and a simple structure of coinsurance or copayments after the deductible has been satisfied.

In contrast, Medicare's cost-sharing requirements are complex and uneven. Traditional Medicare has a $1,132 deductible for inpatient hospital stays and a separate $162 deductible for outpatient services. It also has a complex set of coinsurance requirements that vary depending on the medical service, and it places a lifetime limit on the number of days a beneficiary is covered for inpatient hospital care. Traditional Medicare does not provide protection against catastrophic health care costs; beneficiaries are potentially at risk for unlimited costs even though they are covered by Medicare.

Most beneficiaries in traditional Medicare are protected from the confusion and financial risk of this structure through supplemental insurance—Medigap, retiree coverage, or Medicaid. As a result, most beneficiaries pay little or nothing out of pocket for their care. The patient's lack of cost awareness coupled with fee-for-service incentives for the provider has contributed to the rapid growth of Medicare spending.

Options include simplifying Medicare's cost-sharing requirements (by creating a single deductible and uniform coinsurance on all services, and adding catastrophic coverage to traditional Medicare) and prohibiting Medigap plans from covering Medicare's deductible.[16] Alternatively, Medigap premiums could be taxed to recapture some of the additional Medicare spending induced by the supplemental coverage.

Simplifying cost-sharing requirements and limiting the scope of Medigap coverage would increase cost awareness and reduce some use of services. Such a policy would rationalize Medicare's benefit structure and reduce federal spending modestly.

Introducing some elements of managed care into fee-for-service Medicare could be more effective in controlling program costs and has the potential to improve patient outcomes. Medicare spending is highly concentrated, with the top 10 percent of beneficiaries accounting for

[16] See Option 21 in CBO, *Reducing the Deficit: Spending and Revenue Options*, March 2011.

more than 60 percent of the program's cost.[17] These high-cost patients have chronic diseases and multiple comorbidities. Lack of coordination among providers leads to duplicative testing, unnecessary services, and inadequate patient follow-up that results in poor care and high costs.

Specialized chronic care management programs that target these complicated patients have the potential to reduce costs.[18] Such programs create a virtual network of providers who see the patient, facilitate the exchange of medical information, and monitor the patient to encourage better adherence to the treatment plan. Medicaid programs have used such programs for their high-cost patients, including dual eligibles who are enrolled in Medicare and Medicaid. A similar approach in Medicare would not fundamentally change the operation of the traditional fee-for-service program.

This policy is obviously much more complex than simply cutting provider payments or charging patients higher copayments. If the policy is successful, program savings could be substantial but lack of certainty means a low CBO savings score.

Unlike the previous two policy approaches, raising Medicare premiums would do nothing to reduce the cost or use of services.[19] Options include raising the basic Medicare Part B premium, increasing the amount that higher-income beneficiaries are required to pay, or establishing a new income-related premium for Part A.

The effect of these premium options is to narrow somewhat the gap between the amount Medicare beneficiaries pay into the program over their lifetimes and the benefits they receive. As Steuerle and Rennane show, beneficiaries stand to receive hundreds of thousands of dollars more in benefits than the total of their payroll taxes and premium payments.[20] Premiums, no matter how high they are set, will not catch up to program costs.

There has been considerable discussion about raising Medicare's eligibility age despite the predictable pushback from interest groups.[21] The rationale for this policy is to reinforce the incentive to delay retirement created by increasing Social Security's full retirement age. Opponents of the provision argue that raising the eligibility age shifts Medicare's costs to seniors and others, and may also result in higher total health spending.[22]

CBO estimates $125 billion in budget savings through 2021 if eligibility is raised from 65 to 67 starting in 2014.[23] More gradual implementation, such as increasing the eligibility age by

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[17] CBO, *High-Cost Medicare Beneficiaries*, May 2005.
[18] See note 57 in Robert A. Berenson and John Holahan, "Preserving Medicare: A Practical Approach to Controlling Spending," Urban Institute, September 2011, http://www.urban.org/health_policy/url.cfm?ID=412405.
[19] Medicare premiums are treated as offsetting receipts in the budget, which appears as a reduction in program outlays. However, raising premiums does not reduce the use of services or their cost.
[20] C. Eugene Steuerle and Stephanie Rennane, "Social Security and Medicare Taxes and Benefits Over a Lifetime," Urban Institute, June 2011, http://www.urban.org/UploadedPDF/social-security-medicare-benefits-over-lifetime.pdf.
[21] Tracy Jan, "Hospitals push hike in age for Medicare," Boston Globe, September 30, 2011, http://articles.boston.com/2011-09-30/news/30230360_1_eligibility-age-hospitals-face-medicare.
[22] Paul N. Van de Water, "Raising Medicare's Eligibility Age Would Increase Overall Health Spending and Shift Costs to Seniors, States, and Employers," Center on Budget and Policy Priorities, August 23, 2011, http://www.cbpp.org/cms/index.cfm?fa=view&id=3564.
[23] See Option 18 in CBO, *Reducing the Deficit: Spending and Revenue Options*, March 2011.

one or two months a year instead of the full two year increase immediately or making the increase effective for people who will not turn 65 for a few years, would reduce the savings.

Some who would be affected by this policy and would otherwise be uninsured could qualify for subsidized coverage in the health insurance exchanges under the Affordable Care Act (ACA). However, the Medicaid expansion mandated by ACA does not apply to people 65 and older. If Congress extends the Medicaid expansion and holds states harmless from the additional cost, that would eliminate much of the savings from this option.

Long-Term Reform

Medicare's uncapped entitlement and fee-for-service incentives have driven a steady but unsustainable rise in program spending. Both patients and providers benefit from increasingly effective and increasingly expensive treatments, and workers are stuck with the bill. Neither patients nor providers have much incentive to hold down costs or provide services in the most efficient way. As the baby boom generation retires, financial burdens on those remaining in the workforce will continue to grow to unaffordable levels. Fundamental changes are needed if we expect to preserve Medicare for the future.

Without structural reforms, Medicare spending will crowd out other federal spending priorities, including support for education, energy, and infrastructure. Budgetary restraint is needed, but it cannot be enforced solely through the supply side of the market. To be effective, consumers must become active purchasers through premium support.

The Federal Employees Health Benefits Program is an example of premium support. Members receive a subsidy to purchase insurance from a wide selection of plans offering a core set of benefits. More expensive plans are available, but the extra premium is paid solely by the enrollee without additional subsidy. That gives an incentive to consumers to select lower-cost plans, and it gives an incentive to the plans to negotiate lower prices with providers and improve their efficiency. Competition drives plans to offer consumers better value as a way to increase market share.

The adoption of the premium support model for Medicare is controversial and complicated. Opponents argue that private plans do not have the market power needed to negotiate payment rates as low as fee-for-service Medicare.

A widely misinterpreted report from CBO on the House Republican premium support plan advanced by Rep. Paul Ryan seems to support that assertion.[24] The report indicates that an average 65-year-old Medicare beneficiary in 2022 would spend $6,000 more under the Ryan plan than under traditional Medicare.

CBO assumed that Medicare would be able to impose ever-increasing reductions in fee-for-service payment rates with no reduction in beneficiary access to care. CBO also assumed that private plans under premium support would have no choice but to pay ever-increasing

[24] Douglas W. Elmendorf, Letter to Hon. Paul Ryan, April 5, 2011, http://www.cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan_Letter.pdf.

amounts to providers to maintain that same level of access. No changes in health care delivery or system efficiency are assumed under premium support, despite the pressure on plans to lower their costs in order to remain competitive in the market.

Both assumptions cannot be correct. Either price controls in traditional Medicare will cause a massive breakdown in service, as suggested by the Medicare actuaries, or premium support will cause the adoption of more efficient delivery methods.[25]

There are numerous issues that must be resolved before premium support could be adopted. The following issues are among the most controversial.

- *Growth rate.* Options include tying the growth in federal support for Medicare to growth in GDP, in the CPI, or in health spending in the rest of the economy. An alternative approach, discussed below, would avoid assigning an arbitrary growth rate on the subsidy, which instead would be tied to actual plan bids in the Medicare market.
- *Traditional Medicare option.* Traditional Medicare might remain a plan option for all beneficiaries or limited to those who are enrolled as of a specific date.
- *Price setting in traditional Medicare.* Some proposals would allow traditional Medicare price mechanisms to operate.
- *Risk selection.* Specific issues include questions about the adequacy of risk adjustment methods and concern that plan designs would attract healthier enrollees and exclude those with greater health needs.

Most of these issues could be resolved by replacing the current flawed bidding process used for Medicare Advantage with competitive pricing for all plans, including traditional Medicare. This approach eliminates arbitrary limits on the Medicare subsidy that could make health care unaffordable for beneficiaries. It also maximizes the benefits of competition without disadvantaging beneficiaries living in rural areas or other markets dominated by one or two large providers.

Under this approach, private plans and traditional Medicare in each geographic market area would submit bids that estimate their cost per enrollee to cover the standard Medicare benefit package. The winning bid would be the lowest amount that cleared the market. The combined capacity of all plans submitting a bid at or below the winning bid would be sufficient to accommodate all Medicare enrollees in that market.

The subsidy for an average beneficiary in each market would be set to cover a fixed percentage of the winning bid. That percentage could be the current average subsidy, which is about 85 percent, or it could be reduced to produce larger budget savings. The subsidy would be risk adjusted, with higher subsidies going to lower income beneficiaries and those with greater health needs.

In some markets, traditional Medicare would be the lowest bidder. That is most likely in rural areas that have one or two hospitals and a limited number of other health care providers,

[25] John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," Centers for Medicare and Medicaid Services, May 13, 2011, http://www.cms.gov/ReportsTrustFunds/downloads/2011TRAlternativeScenario.pdf.

and markets in which a few key providers have substantial leverage to negotiate high payment rates. In other markets where there is more robust competition among providers, private plans will be able to undercut Medicare's cost.

By tying Medicare subsidies to actual bids, all beneficiaries are assured that they will have access to at least one health plan that offers the standard set of benefits at no more than the Part B premium. Seniors who wanted a more expensive plan would pay the additional premium out of their own pockets.

Robert Coulam, Roger Feldman, and Bryan Dowd have estimated that a fully implemented competitive pricing system for Medicare would save $550 billion over ten years.[26] If this system was phased in gradually, they estimate the savings at $460 billion.

This approach is a fair test of the competitive model. It preserves full government funding for basic Medicare benefits. Unlike other proposals that set arbitrary limits on the subsidy, beneficiaries would not be exposed to the risk of excessive cost growth. Full competitive bidding also preserves traditional Medicare as an option. Unlike the current system, traditional Medicare would compete fairly without any special advantages over private plans—and private plans would have no special advantages over traditional Medicare.

Conclusion

The United States is on an unsustainable fiscal path. The recession that ended in 2009 was the longest downturn since the Great Depression. The ensuing recovery has been anemic, with unemployment hovering around 9 percent. Federal budget deficits in the last three years have been higher than at any time since World War II. According to the Congressional Budget Office, the $1.3 trillion budget deficit that it projects for 2011 will be the third-largest shortfall in the past 65 years.[27]

The Joint Select Committee on Deficit Reduction is charged with developing a comprehensive plan for long-term debt and deficit reduction. That plan will include recommendations for more aggressive cost reduction in Medicare than would occur under the sequester specified in the Budget Control Act. Its provisions will include many of the near-term options proposed by the Medicare Payment Advisory Commission, the Congressional Budget Office, and other expert groups. Such options are necessary because they can be implemented expeditiously and can garner favorable budget scores. But many of those options do nothing to address Medicare's fundamental structural defects.

The Committee has an obligation to think more broadly. If we ever hope to bend Medicare's cost curve, we must change the financial incentives that drive program spending to increasingly unaffordable levels. A well-designed premium support program can take full

[26] Robert F. Coulam, Roger Feldman, and Bryan E. Dowd, "Better Prices--Through Competitive Bidding--Can Help Solve Medicare's Fiscal Crisis," American Enterprise Institute, August 26, 2011, http://www.aei.org/article/104058, and Robert F. Coulam, Roger Feldman, and Bryan E. Dowd, *Bring Market Prices to Medicare*, AEI Press, November 2009.

[27] Congressional Budget Office, *The Budget and Economic Outlook: An Update*, August 2011.

advantage of market competition to drive out unnecessary spending and increase Medicare's value to beneficiaries. This is safe and reasonable approach to lowering program costs. It is also our best hope for real Medicare reform.